STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for recertification and state licensure survey.

Dates of survey: 1/24/11-28/11

Facility number: 000418
Provider number: 155565
AIM number: 100274870

Survey team:
Laura Brashear, RN, TC
Mary Weyls, RN
Teresa Buske, RN

RECEIVED
FEB 21 2011
LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

approved 2/24/11 MP

Census bed type:
SNF/NF: 47
Total: 47

Census payor type:
Medicare: 4
Medicaid: 32
Other: 11
Total: 47

Sample: 12
Supplemental: 2

These deficiencies also reflect state findings in accordance with 410 IAC 16.2.

Quality review completed 2-2-11
Cathy Emswiller RN

F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164	**This Plan of Correction constitutes the written allegation of compliance for the Deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.** **Hickory Creek at Sunset desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective 02/28/2011.** **<u>F164- 483.10(3), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</u>** **It is the policy of this facility to ensure a resident's right to personal privacy during personal care, and medical treatment through accommodations, including**

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Carrie Bailey | ADMINISTRATOR | 2/18/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 1 Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide full visual privacy to 1 of 2 residents observed receiving dressing treatments in a sample of 12, [Resident #4] and 1 of 1 resident observed receiving incontinence care in a supplemental sample of 2 [Resident #38] in that vertical window blinds in the residents' rooms lacked multiple slats and or blind wasn't closed, which resulted in the residents being visible from the outside.	F 164	**window coverings such as window blinds.** **What corrective action will be done?** The Maintenance Director replaced the missing vertical slats in the window blinds in the rooms of resident # 4 and resident # 38 on 01/27/2011. CNAs # 1, # 2, and QMA # 3 were rein-serviced by the Director of Nursing regarding the need to ensure resident privacy during personal care and medical treatment. 01/26/2011. **How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** The CNAs and Maintenance Director assessed the window blinds in each resident room to ensure the window blinds was in good working order and had no missing vertical slats. Any	

2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 2 Findings include: 1. On 1/25/11 at 10:30 a.m., CNAs #1, #2, and QMA #3 were observed to provide incontinence care and a mechanical lift transfer to Resident #38. The resident was observed in bed, with the foot of the bed against the wall, under the exterior window. The window blind on the window was observed missing multiple wide, vertical slats. During an interview at that time CNA #1 indicated privacy could not be maintained with the missing slats. The resident's lower body was exposed during the incontinence care. After completing the care, the resident was transferred from the bed to chair with a mechanical lift. Resident #38's clinical record was reviewed on 1/27/11 at 10:50 a.m. The Minimum Data Set [MDS] assessment, completed on 8/4/10, coded the resident with severe cognitive impairment and required total assistance of one for hygiene. The facility's policy titled "Perineal Hygiene," with revision date of 11/05, provided by the DON on 1/28/11 at 11:00 a.m., included, but was not limited to: "1. Provide for privacy." 2. On 1/26/11 at 9:40 a.m., LPN #5 was observed to provide a dressing treatment to Resident #4's foot. The resident was observed seated in the wheelchair in her room, in front of the exterior window during the treatment. The window blind was observed not to be closed all of the way, and for there to be multiple missing vertical blind slats. Privacy from the window was not provided. The facility's policy titled "Dressing Change, Clean and Sterile," dated June, 2004, provided by	F 164	identified window blind in need of repair or replacement was completed by the Maintenance Director on 02/11/2011. **What measures will be put into place to ensure this practice does not recur?** On a daily basis the Environmental Services staff will assess the working condition of window blinds in each resident room to ensure they are no missing vertical slats and operating properly to ensure resident privacy. Any window blinds in need of repair or replacement will be promptly reported and corrected by the Maintenance Director. During weekly rounds the Maintenance Director and Environmental Services Director will assess the window blinds in each resident room to ensure there are no missing vertical slats. All staff was rein-serviced on 02/15/2011 regarding the need to ensure resident's privacy during	

F-164

personal care and medical treatments by closing the window blinds. Staff was also reinserviced on the need to report for repair any window blind not in good working order or in need of replacement.

How will corrective action be monitored to Ensure the deficient practice does not recur and what QA will be put into place?

The Maintenance Director will bring the results of weekly monitoring efforts to the monthly QA&A Committee meeting for the review of window blind repairs on an ongoing basis.

The Director of Nursing or Designee will do random audits ensure privacy is provided to residents during personal care and medical treatment. The audits will consist of 5 times a week for the first 2 weeks, 3 times a week for the next 3 weeks, and randomly on an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 3 the DON on 1/28/11 at 11:00 a.m., included, but was not limited to, "1. Provide privacy." 3.1-3(p)(2) 3.1-3(p)(4)	F 164	ongoing basis for the next six months. The audits will be brought to the monthly QA&A Committee meeting for review and recommendations for the next six months. **Date of Compliance:** 02/18/2011	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to have the most recent standard survey available for examination and failed to post a notice of the availability of the survey. This had the potential to affect 47 of 47 residents residing in the facility. Findings include: On 1/24/11 at 12:30 p.m., a book titled survey binder was noted on top of the piano. The piano was located in the dining room area. A complaint survey dated, 12/12/10 , was the only survey noted in the binder. During an interview on 1/24/11 at 1 p.m., the Administrator approached surveyor and indicated	F 167	**<u>F167 – 483.10(g)(1) RIGHT TO SURVEY RESULTS- READILY ACCESSIBLE</u>** **It is the policy of this facility to make survey results available for examination and post in a place readily accessible to residents and to post a notice of their availability.** **What corrective action will be done by the facility?** On 01/24/2011, the survey binder located on the piano was updated to include copies of all 2010 surveys and plans of correction. On 01/31/2011, a notice was posted in the facility to inform	

5

F-167

residents of the availability of survey results.

How will the facility identify other residents having the potential to be affected by the same practice and what correction action will be taken?

No other residents were affected.

What measures will be put into place to ensure this practice does not recur?

During daily rounds the facility Administrator or Designee will ensure the availability and accessibility of the survey binder and document the results. The Activity Director will inform & educate the residents as to the location of the survey binder and the fact that they can look at it any time they wish during the next scheduled Resident Council meeting on (date). This will be documented in the minutes of the Resident Council meeting.

F167

How will the corrective action be monitored to ensure the efficient practice does not recur and what QA will be put into place?

Documented results of the availability and accessibility of the survey binder will be brought to the monthly QA&A meeting for review and recommendations.

Date of Compliance: 02/18/2011

F282 It is the policy of this facility for the services provided or arranged by the facility to be provided by qualified persons in accordance with each residents written plan of care.

What corrective action will be done by the facility?

The DON removed the approach for "Remove lap tray during meals while you are directly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 4 the most recent annual Recertification survey was not in the survey binder. During an interview on 1/28/11, during General Observation Tour which began at 11 a.m., the Administrator indicated a notice concerning whereabouts of the survey results was not available. 3.1-3(b)(1)	F 167	supervising me" from resident #7 plan of care on 1-27-11 All nursing staff have been re-educated on 2-15-11 on notifying the IDT team of failed approaches related to the plan of care.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to follow a plan of care to remove a restraint for 1 of 1 resident reviewed in a sample of 12, when closely supervised during meals. [Resident #7] Findings include: During an interview on 1/24/11 at 11:15 a.m., with LPN #5 Resident #7 was identified as utilizing a lap tray restraint. On 1/26/11 at 12:20 p.m., Resident #7 was observed in the Assisted Dining Room [ADR] seated in a wheelchair being fed by staff with a lap tray restraint on. On 1/26/11 at 5:30 p.m., the resident was	F 282	**How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** The interdisciplinary team has reviewed resident's with restraints to ensure approaches are still applicable to the resident's current needs. **What measures will be put into place to ensure this practice does not recur?** The DON/Designee will review the focus charting, 24 hour report and other relevant information as part of her routine when coming on duty at least 5 days a week. She will bring her findings, including any changes in	

8

F282

residents' condition and/or needs to the next scheduled morning management meeting that occurs at least 5 days a week. The IDT team will review this information and will recommend changes to the written plan of care as a result of the DON's findings. The DON will communicate any changes to the plan of care to the nursing staff that same day through the C.N.A. assignment sheets and the Nursing communication book.

At the weekly care plan meeting the IDT will audit an additional resident's plan of care at random to ensure services provided in accordance with the written plan of care. This will be done weekly until all residents' care plans have been reviewed on a random basis. Once that has occurred, the QA&A Committee members will determine the continued frequency of the random reviews until 100% compliance has been achieved over a 90 day period of time. At that point the QA&A Committee members may choose

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5 observed in the ADR, in the wheelchair with lap tray restraint on while being fed. On 1/27/11 at 12:35 p.m., Resident #7 was observed in the ADR in the wheelchair with lap tray restraint on, being fed. Resident #7's clinical record was reviewed on 1/26/11 at 4:05 p.m. A plan of care which addressed use of padded lap tray when in wheelchair and most recent goal date of 4/27/11 included, but was not limited to "Remove lap tray during meals while you are directly supervising me." 3.1-35(g)(2)	F 282	to discontinue the random reviews if they so desire. **How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The DON/Designee will bring the results of her monitoring to the monthly QA&A meeting for review and recommendation. The DON/designee will follow through on any additional recommendations made by the committee members at that time and will report the results of those recommendations to the next scheduled QA&A committee meeting. This will continue on a ongoing basis. **Date of compliance-** 2-15-11	
F 286 SS=E	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain complete 3.0 Minimum Data Set Assessments of 9 of 11 residents reviewed in an sample of 12, required to have a Minimum Data Set Assessment, in that completed 3.0 Minimum Data Set assessments were not maintained on the residents' clinical record, or accessible to all professional staff members. [Residents #7, #32, #34, #23, #13, #19, #36, #46, and #35] Findings include: 1. On 1/26/11 at 10:50 a.m., Resident #32's	F 286	**F286 – It is the policy of this facility to maintain resident assessments completed within**	

10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 6 clinical record was reviewed. A 3.0 Minimum Data Set Assessment, completed on 12/17/10 was not on the resident's clinical record, or accessible to professional staff. Section A [Identification Information], Section V [Care Area Assessment (CAA) Summary, and Section Z [Assessment Administration] were on the clinical record. Sections B [Hearing, Speech, and Vision,] Section C [Cognitive Patterns], Section D [Mood], Section E [Behavior], Section F [Preferences for Customary Routine and Activities], Section G [Functional Status], Section H [Bladder and Bowel], Section I [Active Diagnoses], Section J [Health Conditions], Section K [Swallowing/Nutritional Status], Section L [Oral/Dental Status] Section M [Skin Conditions], Section N [Medications], Section O [Special Treatments, Procedures, and Programs,] Section P [Restraints], Section Q [Participation in Assessment and Goal Setting], were not on the clinical record. 2. On 1/26/11 at 4:05 p.m., Resident #7's clinical record was reviewed. A completed 3.0 Minimum Data Set assessment, completed on 10/22/10, was not available on the resident's clinical record, or accessible to all professional staff. Sections A [Identification Information] and Section Z [Assessment Administration] were the only sections on the clinical record. Sections B, C, D, E, F, G , H, I, J, K, L, M, N, O, P, and Q, were not on the clinical record. 3. On 1/27/11 at 12:00 p.m., Resident #34's	F 286	**the previous 15 months in the active record.** **What corrective action will be done by the facility?** Accessibility to the residents' MDS will be provided to the nurses via the computer for review 24/7. **How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** All residents MDSs will be accessible to the nursing staff via computer for review 24/7. **What measures will be put into place to ensure this practice does not recur?** Education will be completed by the DON and /or MDS coordinator to the licensed nursing staff on logging onto the MDS system and viewing the MDS. Step by step instructions will be provided and a copy kept	

11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 7 clinical record was reviewed. A completed 3.0 Minimum Data Set assessment, completed on 11/17/10 was not available on the resident's clinical record, or accessible to all professional staff except during normal business hours. Sections A and Z were the only sections on the record. Sections A [Identification Information] and Section Z [Assessment Administration] were the only sections on the clinical record. Sections B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, and Q were not on the clinical record. 4. Resident #23's clinical record was reviewed on 1/26/11 at 11:20 a.m. The most recent quarterly assessment was noted to have been completed on 12/14/10. The only section of the 3.0 quarterly assessment available on the clinical record were sections A and Z. Sections B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, and Q were not on the clinical record. 5. Resident #13's clinical record was reviewed on 1/24/11 at 3 p.m. Documentation was noted, indicating an annual 3.0 assessment was completed on 10/30/10. The only sections of the 3.0 annual assessment available on the clinical record was section A, Z and X [Correction Request.] Sections B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, and Q were not on the clinical record.	F 286	in each medication room for referral as needed. **How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?** The MDS coordinator & /or the DON will have each nurse sign onto the computer to view a MDS weekly x 2 and then monthly times two. Results will be brought to the QA & A meeting and further recommendations of the QA & A committee followed. **Date of Compliance- 2/27/11**	

12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 8 6. Review of the clinical record of Resident # 19 on 1/24/11 at 2:40 p.m. indicated the quarterly Minimum Data Set (MDS) 3.0 assessment had been completed on 12/30/10. The quarterly MDS assessment on the clinical record had only the sections of A and Z. The entire assessment was not a part of the clinical record. Sections B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, and Q were not on the clinical record. 7. Review of the clinical record of Resident # 36 on 1/26/11 at 2:30 p.m. indicated the quarterly Minimum Data Set (MDS) 3.0 had been completed on 11/17/10. The quarterly MDS assessment on the clinical record had only the sections of A and Z. The entire assessment was not a part of the clinical record. Sections B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, and Q were not on the clinical record. 8. Review of the clinical record of Resident #46 on 1/27/11 at 11:35 a.m. indicated the quarterly Minimum Data Set (MDS) 3.0 assessment had been completed on 12/23/10. The quarterly MDS assessment on the clinical record had only the sections of A and Z. The entire assessment was not a part of the clinical record. Sections B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, and Q were not on the clinical record. 9. Review of the clinical record of Resident # 35 on 1/27/11 at 3:25 p.m. indicated the initial Minimum Data Set (MDS) 3.0 assessment had been completed on 1/19/11. The quarterly MDS assessment on the clinical record had only the sections of A, V and Z. The entire assessment	F 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 9 was not a part of the clinical record. Sections B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, and Q were not on the clinical record. Interview of the MDS coordinator LPN #8 on 1/24/11 at 12:15 p.m. indicated the entire Minimum Data Set (MDS) 3.0 assessments were not printed and included in the residents' clinical records. The LPN indicated the corporation had decided not to have them print the entire MDS assessments due to the use of ink and paper. The LPN indicated the complete MDS 3.0 assessments were maintained in the computer. The LPN also indicated the nursing staff did not have access to the MDS 3.0 assessments and computer. Interview of LPN # 9 on 1/25/11 at 3:05 p.m. indicated she was unaware of having access to the Minimum Data Set (MDS) 3.0 assessments that were maintained in the computer. Interview of LPN #5 on 1/25/11 at 3:25 p.m. indicated computer terminals were located in the MDS office, Director of Nursing office and Administrator office. However, the offices were locked when the staff persons were not in the building. Review of the facility's current policy and procedure titled " Electronic MDS 3.0 storage" [no date] on 1/24/11 at 12:15 p.m. indicated "Policy: It is the policy of [name of corporation] to electronically maintain MDS 3.0 records with the exception of electronic signatures. [name of corporation] has chosen to manually sign the MDS 3.0 in all applicable required locations. [name of corporation] will keep the following MDS	F 286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286	Continued From page 10 3.0 sections on the clinical record: Section A, Section Z, Section V if a comprehensive MDS is completed, and section X if applicable; i.e. a modification or inactivation has occurred. The facilities will ensure that clinical records are easily and readily accessible to staff, State agencies, CMS and others who are authorized by and need to review the information in order to provide care to the resident. (RAI [Resident Assessment Instrument] pg. 2.6) . Procedure : Upon completion of each MDS 3.0 assessment the following sections will be printed : A. Section A B. Section Z with applicable signatures, C. Section V with applicable signatures, comprehensive assessment , D. Section X with applicable signature if a modification or inactivation has occurred. The printed/signed sections will then be placed in the chart according to [corporation name] chart order policy. "	F 286		
F 356 SS=C	3.1-35(g) 483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data	F 356	**F356 483.3.30(e) POSTED NURSE STAFFING INFORMATION** **It is the policy of this facility to post the nursing staffing data on a daily basis in a prominent place readily accessible to residents and visitors including actual time/hours worked by category.** **What corrective action will be done by the facility?** The posted nursing staffing data was relocated on 01/28/2011, from the bulletin board located at the nurse's station to the counter at the nurse's station to provide more accessibility to residents and visitors. The posted nursing staffing data sheet posted on the day of the survey did include the actual time/hours worked by category. Any other staffing information presented to the surveyor by the MDS Coordinator was not the posted nursing staffing data.	

15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 11 specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to post staffing in a place readily accessible to residents and visitors and failed to provide actual hours worked by the staff. Findings include: During general observation of the facility on 1/28/11, which began at 11 a.m., staffing was not observed to be posted. The Administrator ask the MDS (minimum data set) coordinator and the coordinator indicated the staffing was on the far east wall of the nursing station. The staffing was not readily accessible to residents and or visitors as it could not be read when standing at the counter of the nursing station. The MDS coordinator pulled the copy of the staffing information down off the wall. The staffing information did not provide the total number of the actual hours worked by the staff.	F 356	**How will the facility identify other residents having the potential to be affected by the same practice and what correction action will be taken?** No other residents were affected. **What measures will be put into place to ensure this practice does not recur?** During daily rounds the facility Administrator or designee will ensure the availability and accessibility of the posted nursing staffing data and document the results. If the data is not posted correctly or is not available, the Administrator or designee will replace it as required immediately. Once that is done, the Administrator or designee will review the process for positing of the nursing staffing with the staff responsible.	

16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 12 A facility policy titled "Staffing-Daily Posting-Indiana and Ohio" dated 1/1/03 with the most recent revised date of 12/05, was provided by the Administrator on 1/28/11 at 12:45 p.m. Documentation was noted indicating the posting will be in a prominent area visible and accessible to residents and visitors and that the posting would include the actual time/ hours worked by category. 3.1-13(i)(4)	F 356	**How will the corrective action be monitored to ensure the efficient practice does not recur and what QA will be put into place?** Documented results of the availability and accessibility of the posted nursing staffing data will be brought to the monthly QA&A meeting for review and recommendations. **Date of Compliance: February 18, 2011**	
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 10 residents in a sample of 12, requiring physician visits every 60 days, were seen by the physician in a timely manner. [Resident #32] Finding includes: Resident #32's clinical record was reviewed on 1/26/11 at 10:50 a.m. A readmission date was noted of 4/6/09. Physician progress notes were	F 386	**F386 It is the policy of this facility to the physician visit will be timely.** **What corrective action will be done by the facility?**	

17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155565	A. BUILDING _____ B. WING _____	01/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT SUNSET	1109 S INDIANA ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 13 noted dated: 1/27/10, 5/12/10, [105 days] 8/28/10, [108 days] and 1/12/11 [136 days.] LPN #9 was interviewed on 1/26/11 at 3:45 p.m. LPN #9 indicated the dates of the progress notes, were the dates the resident was seen by the physician and the resident had not been hospitalized or seen by the Medical Director during the period of time. A facility policy titled "Physician Visits," revised 8/09, provided by the Administrator on 1/28/11 at 12:30 p.m., included, but was not limited to: "NF residents will be seen by their physician every 60 days. ...1. Medical Record Designee will track physician visits to provide that residents are being seen on a timely basis. 2. Medical Record Designee will notify physicians of visits due at the beginning of each month, and will keep documentation of notifications. 6. If a physician is continually untimely with visits, the Administrator will notify the Medical Director for assistance/guidance. Administrator and/or Medical Director will send a letter to the physician requesting a visit be made for regulatory compliance." 3.1-22(d)(1)	F 386	Resident #32 was seen by the physician on 1/12/11 and is current regarding the physician visits at this time. **How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** The Medical Records Designee has reviewed all clinical records for compliance with physician visits. **What measures will be put into place to ensure this practice does not recur?** The Medical Records Designee will monitor physician visits per the "Physician Visit" policy and procedure. (Attachment) She will contact the physician by letter/fax to remind him/her of required resident visits. She will also attempt to contact physician by telephone to remind him/her of required visit.	

18

The Medical Records Designee will inform the Administrator of any noncompliant physician directly regarding the need for the required routine visit.

The Medical Director will also be notified and will follow up with the Physician when needed. He will also see the resident himself if the physician is delinquent and has not come to the facility as requested.

How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?

The Medical Records Designee will bring results of her audits to the monthly QA&A committee meeting for review and recommendations. She will follow through as directed by the committee. Her monthly audits of physician visits will continue

on an ongoing basis to make sure that physician visits continue to meet the regulation for timely visits.

Date of compliance-2/15/11